UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2013
QUALITY IMPROVEMENT INCENTIVE (2)(ii) APPLICATION
New Patient Lift System, Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2013

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility purchased, at a minimum, one new patient lift capable of lifting patients weighing up to 400 pounds each.
- ☐ A detailed description of the lift(s) purchased is attached.
- ☐ The patient lift(s) were purchased by May 31, 2013
- ☐ The patient lift(s) were installed between July 1, 2011 and May 31, 2013.
- ☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc.

Qualifying facilities may receive up to $45 per Medicaid Certified bed per patient lift under this incentive, with a maximum of $90 per Medicaid Certified bed (counts as at 7/1/2012).

This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is $575.80 per Medicaid Certified bed (count as at 7/1/2012).

Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures

Total Reimbursement Requested (should match spreadsheet): $_____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.
By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____
Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-323-1595 <or> Mail instructions: http://health.utah.gov/medicaid/stplan/longtermcare.htm

For Medicaid use only:	
Amount reimbursed	Date Paid